Enhanced Personal Health Care

Collaboration with the Provider Clinical Liaison Team

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What is Patient Centered Primary Care?

Today's health care system is highly fragmented, based on episodic intervention and shows inconsistent adherence to evidence-based guidelines but this has been rapidly changing.

Patient Centered Primary Care model aims to change that by asking physicians to engage in those comprehensive primary care functions that move us towards coordinated, evidence-based, care model and have the greatest impact on achieving the triple aim of improved quality, patient experience and affordability:

- **Risk stratified care management**
- **Coordination of care across the continuum**
- **Improved access**
- **Shared decision making and accountability with the patient and patient's caregiver**
- **Promotion of wellness and prevention**

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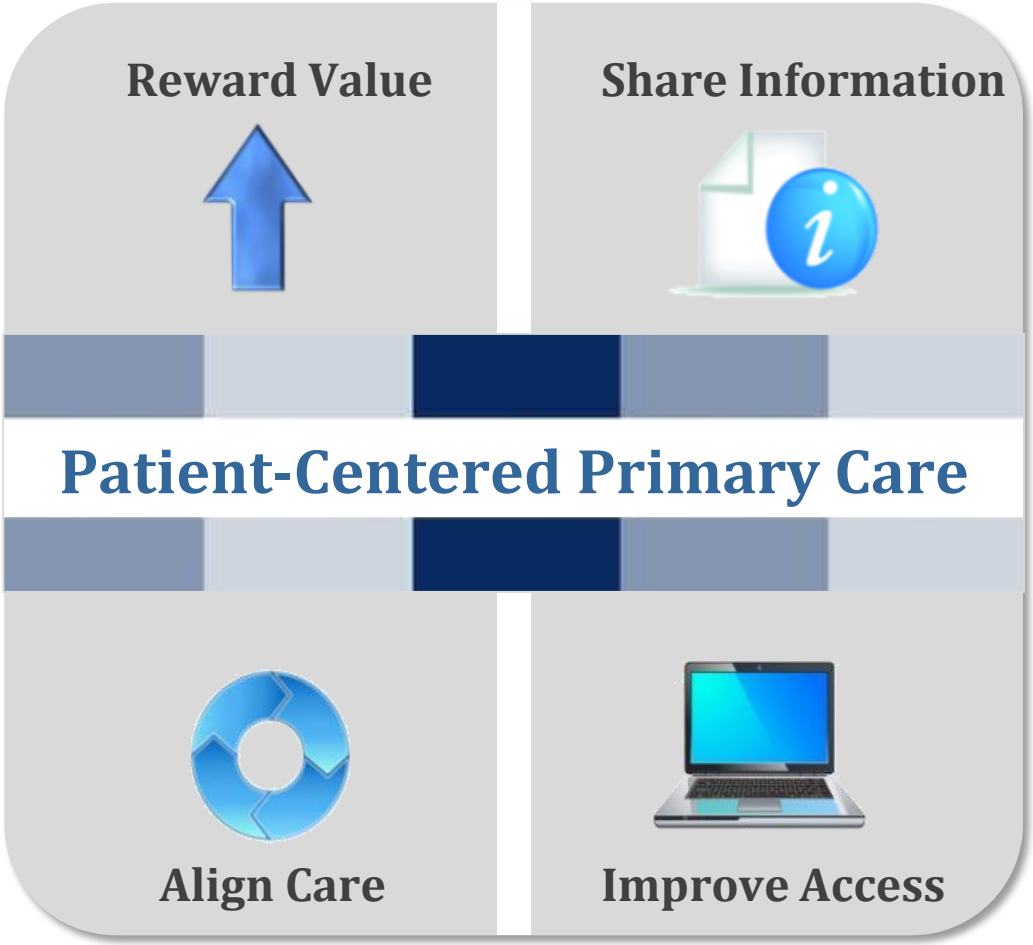
What is Patient Centered Primary Care?

A patient-centered care model that

- ***rewards improvements in quality outcomes and affordability; and***
- ***gives primary care physicians the tools they need —including meaningful and actionable information and aligned payment models—to successfully manage the health of their patients.***



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How do members benefit?

THIS PROGRAM IS DESIGNED TO:

- optimize our members' health,
- improve their health care experience and
- make health care more affordable.

MEMBERS WILL BENEFIT FROM BETTER OUTCOMES, MORE PERSONAL AND CONTINUOUS INTERACTION WITH THEIR PCP-LED TEAM, ENHANCED CARE MANAGEMENT SUPPORT, INFORMATION AND, ULTIMATELY, SAVINGS.

IF WE ELIMINATE UNNECESSARY COSTS IN THE SYSTEM, EVERYONE BENEFITS.

- This program has no impact on members' premiums, however, if we are successful in reducing medical spend in the long term, this could potentially result in slowing the growth of premiums.

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Care Coordinator and Practice Care Team

Care Coordinator

Manages and coordinates the care plan; coaches and offers self-management support; Implements plans; assesses barriers and stressors; supports change

Office Manager

Builds relationships; explores needs and preferences; collects administrative information

Nurse/MA

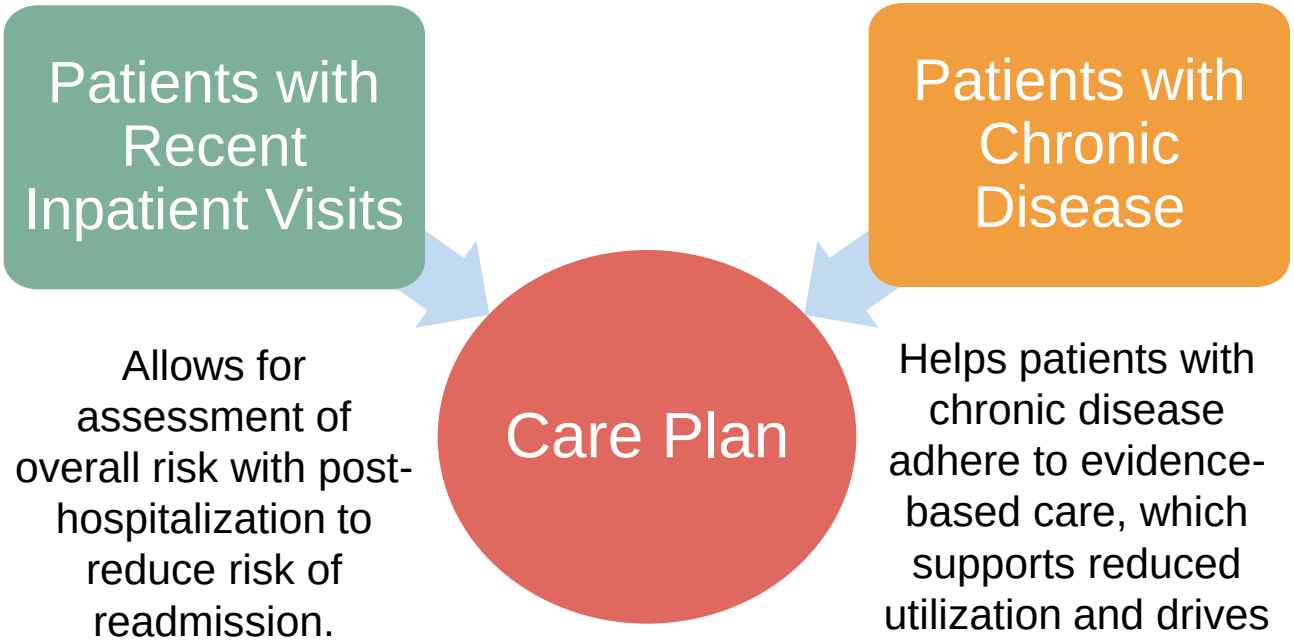
Handles initial screening, standing orders and flow sheets

Provider (MD, PA, NP, Care Team)

Sets a shared agenda for each visit; reviews chronic, preventative and acute care issues; collaborates to set self-management goals; creates care plan using shared decision-making; reviews patient experience

Identifying the Need for Outreach and Care Planning Interventions

Two populations have been identified that will benefit most from care plans:



Allows for assessment of overall risk with post-hospitalization to reduce risk of readmission.

A detailed approach to care that is customized to an identified patient's needs

Helps patients with chronic disease adhere to evidence-based care, which supports reduced utilization and drives down the cost of care.

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Data available to the care teams

Patient attribution	Care management
Attribution list	Hot Spotter
Detailed attribution list	Inpatient authorization
No-longer-active list	Care opportunity
	Emergency room

These lists will help the care team track the full panel of attributed patients by identifying patients who will be included in each practice's attributed patient population.

These lists will help the care team manage high-risk patients, identify gaps in care and offer appropriate follow-up immediately post-acute discharge.

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Patients With Identified Gaps In Care

Care Opportunity Report:

Identification of patients with “care opportunities” i.e., active or potential gaps in care associated with clinical quality metrics.

Report can be sorted by level of urgency in terms of outreach. Practices can implement these quality measures into registries for tracking, reporting, and outreach.

Includes: demo, next clinical due date associated with the measure, urgency around potential opportunity/gap in care color coded by status: complete, green; due in 60 days, orange; due in 30 days, yellow; past due, red.·

Report frequency: monthly.

Taking Action based on Report Data

Flagging charts

Setting up alerts in chart to alert care team of gaps in care, care plan issues/interventions and other important info

Huddles

Tool to enhance communication, teamwork, efficiency, and patient safety.

Notifying provider

Care coordinator alerts providers to possible gaps in care identified in reports or other systems.

Outreach to patients

Care Coordinator or other office staff contacts patients identified on reports to work to close gaps in care and begin creation of care plan.

Referrals to health plan Programs

Discussion of health plan programs:

- Case Management
- Disease Management/Condition Care
- Behavioral health

Review of referral form and process

An important note

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